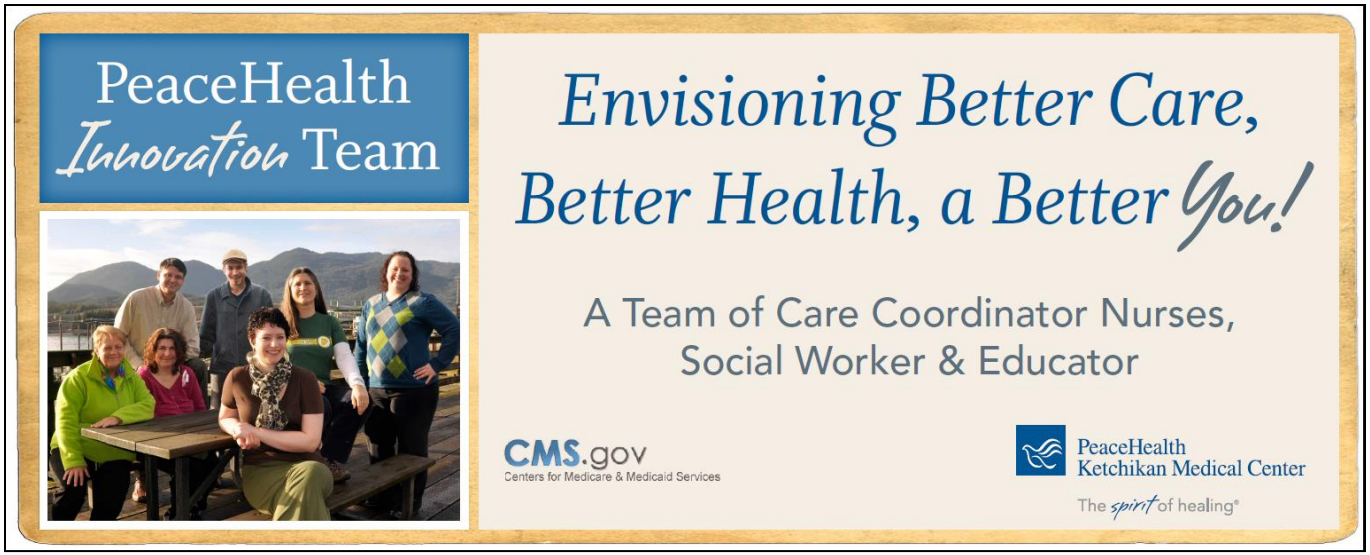
PeaceHealth Medical Group

CMS Innovation Award

Ketchikan Medical Center



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Results Overview

15-22% reduction in payments (depending on analysis)

27% reduction in 30 day “all-cause” readmissions

Improvement in select clinical outcome areas

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Reduction in Payments

Method #1: **Per Beneficiary Per Encounter**, "Per Capita Cost reduction"

Equation: $\frac{\text{Total CMS payments}}{\text{Total encounters}}$

Payer	FY12	FY13	FY14 *PROJECTED*	Change- Baseline FY12
CMS	$536/encounter	$457/encounter	$418/encounter	-22%

Method #2: **Historical Total Dollars**

Payer	FY12	FY13	FY14 *PROJECTED*	Change- Baseline FY12
CMS	11,020,737	10,422,101	$9,404,306	-15%

Note: Encounters every year have increased.

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Reduction in Payments- Looking at Hospital vs. Clinic Costs

Payer	Clinic PBPE			Hospital PBPE		
	2012	2013	2014	2012	2013	2014
CMS	$134	$130	**$118**	$1,187	$921	**$832**

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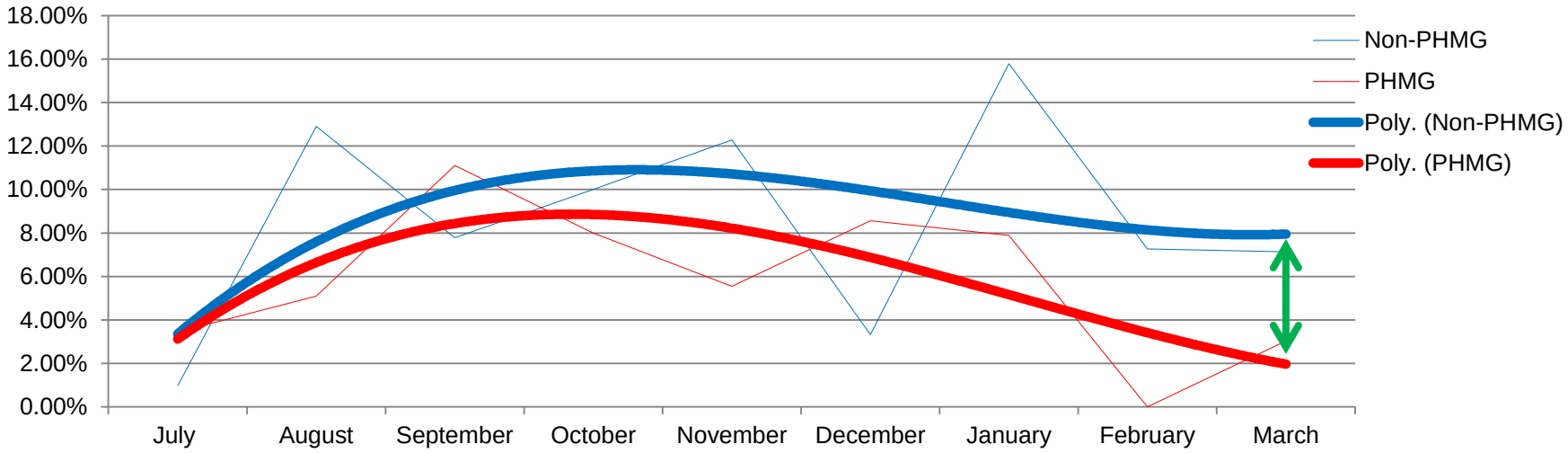
30 Day "All Cause" Readmissions



Rate	**.98%**	**12.9%**	**7.79%**	**10%**	**12.28%**	**3.33%**	**15.78%**	**7.27%**	**7.14%**	**8.08%**
Numerator	1	8	6	8	7	2	9	4	4	49
Denominator	102	62	77	80	57	60	57	55	56	606
Rate	**3.5%**	**5.1%**	**11%**	**8%**	**5.6%**	**9%**	**7.9%**	**0%**	**3%**	**5.88%**
Numerator	1	2	3	2	2	3	3	0	1	17
Denominator	29	39	27	25	36	35	38	27	33	289

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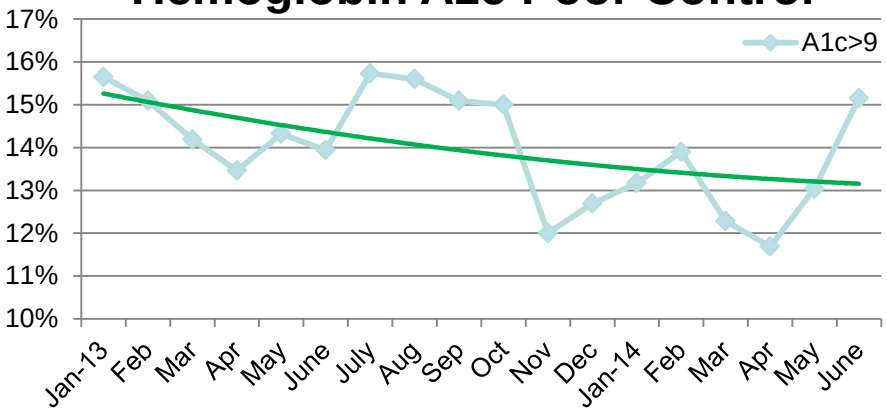
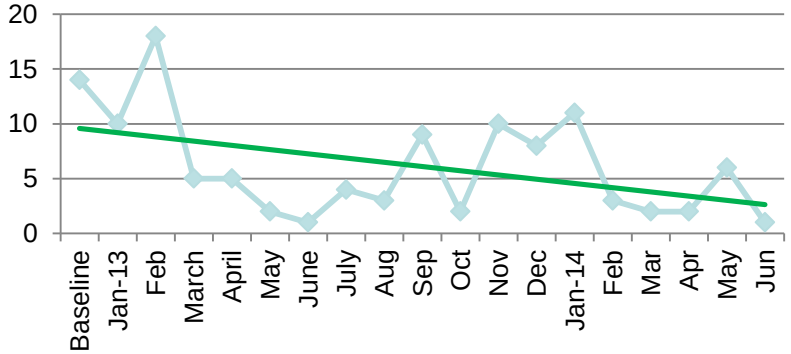
Improvement in Health Maintenance

(Some examples)

Hemoglobin A1c Poor Control

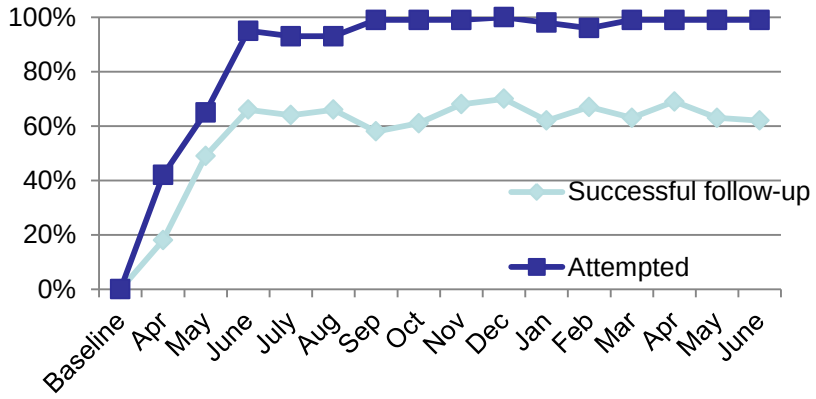


Emergency Room Clinic Referrals



Hypertension patients on active management plan has risen from 84% to 89%

Discharged Patient Follow-Up



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Staff/Operations

- 3 Primary Care Care-Coordinators
  (1 LPN and 2 RNs)
- 1 .5 FTE Pediatrics
- 1 Social Worker
- 1 RN Educator- Medical Office Assts.

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Primary interventions

1. Transition of Care
   - ‘Next steps’ to care (appointments, tests/studies, acquiring medications)
   - Medication reconciliation and teaching
   - Psycho-social hurdles
2. Primary Care Provider Referrals
3. Diabetes Outreach/Upcoming appointments
4. Health Maintenance
5. Community Outreach/ Collaboration/ Catalyst

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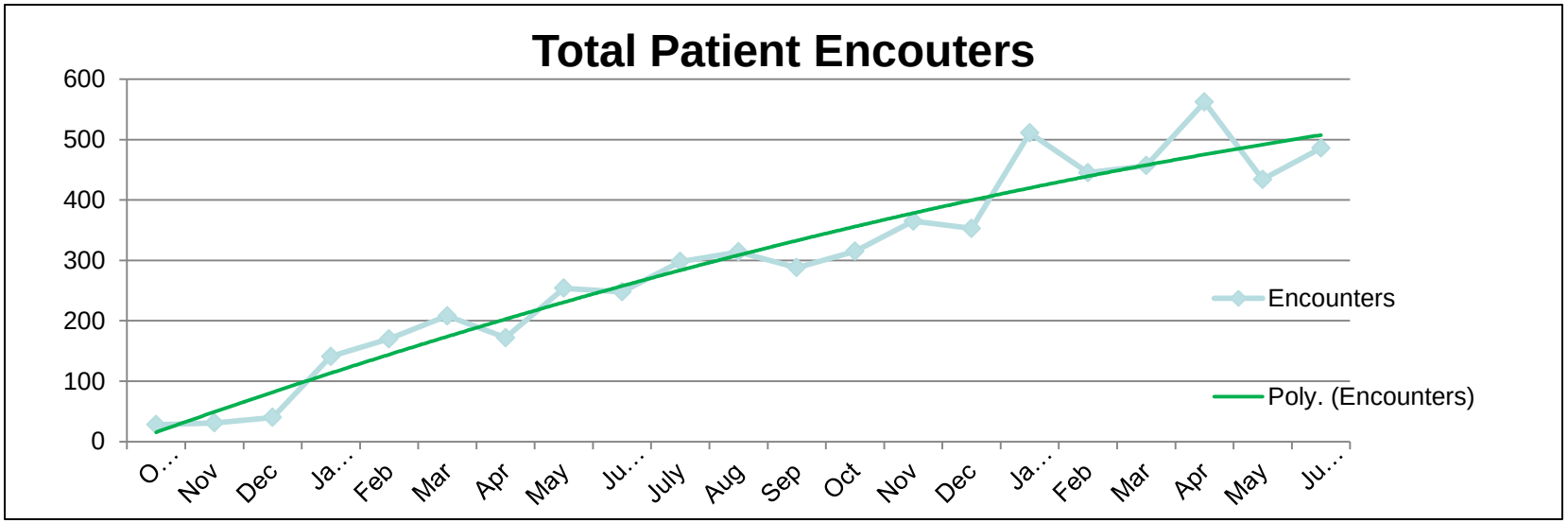
Program Participants (Since Inception)

- **4828 Total Encounters**



- **2500 Unique Patients** (July 14, 2014)
  - ➢11.5 months ahead of target

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Challenges/Learnings

- Transition of Care is very labor intensive
  - Consider risk stratification of patients
  - Understanding the ‘teaching moment’
- Upcoming diabetic patient appointments (“Scrub”)
- Non-medical ‘hurdles to care’ remains high
- Utilization of social work skills by MSW and Care Coordinators is significant
- Culture of *‘we just can’t help’* is gone

“Secret to navigate complexity is simplicity”